



Agile Patency Capsule Record

Patient Name: _____ DOB: _____ MRN#: _____

Indication: _____

Referring Provider: _____ Ordering Provider: _____

Pre-Procedure

- | Yes | No | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Defibrillator |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | MRI Scheduled |
| | | |
| <input type="checkbox"/> | | Pre-Capsule Preparation Followed |
| <input type="checkbox"/> | | Contraindications Reviewed |
| <input type="checkbox"/> | | Patient Consent Obtained |

Procedure

Date: _____ Arrival time: _____ NPO: _____

Capsule ingested at: _____

Difficulty ingesting: Yes No

Abdominal X-Ray schedule at: _____ on: _____ time: _____

Order given to patient

Order faxed

Nurse signature: _____ Date: _____



1015 S. Hackett Rd., Waterloo, Iowa 50701
319.234.5990

CVMS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
SPANISH : ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
CHINESE : 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電